

PART 14 INDIVIDUALS IN MEDICAL INSTITUTIONS

The rules in this Part are used for individuals who are institutionalized. An institutionalized individual is one who applies for or receives Medicaid and is expected to stay at least thirty days in a hospital or nursing facility.

A Community Spouse is a person who, according to Maine state law, is married to an institutionalized spouse.

A spouse living in a AFH, FRBH, CRBH, RCF, or AFCH (as defined in Part 12, Section 1), or receiving Home and Community Based Waiver services (see Part 13) is considered a Community Spouse.

Eligibility for an institutionalized individual requires that the individual:

- Meets the definition of Institutionalization
- Has a coverable group
- Has a medical need classification
- Meets asset criteria
- Meets income criteria

If eligible, a cost of care will be determined based on the individual's income.

Individuals who are changing from institutionalized status to community status must be given advanced notice if coverage is ending.

SECTION 1 INSTITUTIONALIZED

Institutionalization: A person is considered institutionalized when he/she resides in a hospital or nursing facility and is expected to remain for thirty consecutive days. A hospital is one that is primarily for the care and treatment of patients with disorders other than tuberculosis or mental disease.

Individuals who die prior to the end of the thirty day period are considered to be institutionalized.

Special income and asset rules are triggered for the person who is institutionalized. These special rules are effective on the first day of the month in which the thirty days of institutionalization starts.

Example:

The individual enters a hospital or nursing facility on March 20th and remains for at least thirty consecutive days. Special income and asset rules are effective March 1st.

Section 1.1 Special income and asset limits

The special income and asset limits for institutionalization are as follows:

- I. Residing in a Hospital -
 - A. Gross income of the individual must be equal to or less than the Categorically Needy Income Limit in Chart 4.1. If the individual's gross income exceeds the Categorically Needy Income Limit in Chart 4.1, eligibility is determined using Medically Needy rules. See Part 7.

- B. Countable assets of the individual must be under \$2,000. If there is a community spouse, the Community Spouse Share of Assets is determined as defined in Section 4.3 of this Part.
 - C. The cost of care for the individual starts in the first full calendar month residing in a hospital. If there is a community spouse, a Community Spouse Monthly Income Allowance and Income Allocation is determined, as defined in this Part.
- II. Residing in a Nursing Facility or skilled section of a hospital -
- A. Gross income of the individual must be less than the private rate for a semi-private room in the facility where the individual resides. If the income of the individual is over the Categorically Needy Income Limit in Chart 4.1 but under the private rate for the facility a deductible must be met (See Section 5 of this Part).
 - B. Countable assets of the individual must be under \$2,000. If there is a community spouse, the Community Spouse Share of Assets is determined as defined in Section 4.3 of this Part.
 - C. The cost of care for the individual starts in the first full calendar month they reside in a nursing facility or skilled level of care. Cost of care is determined as defined in this Part.
- If there is a community spouse, a Community Spouse Monthly Income Allowance and Income Allocation is determined, as defined in Section 6.1.1 of this Part.
- D. If the gross income of the individual exceeds the private rate for a semi-private room in the facility where the individual resides:
 - 1. the individual may be eligible under Medically Needy, but no nursing care costs are covered;
 - 2. a Community Spouse Asset Allocation is given (See Section 4.3 of this Part); and
 - 3. no cost of care is determined and as a result no Community Spouse Monthly Income Allowance is given.

SECTION 2 COVERABLE GROUPS

Individuals applying for nursing facility coverage must have a Medicaid coverable group. This can be any coverable group including Family - Related. The individual need not be in a elderly or disability coverage group.

If the individual only qualifies for a coverage group that does not pay for nursing care services the individual is not given a cost of care since nursing care services are not being paid. This includes Non-Categorical, HIV Waiver and Breast and Cervical Cancer groups (See Part 9).

SECTION 3 MEDICAL NEED CLASSIFICATION

In order for Medicaid to pay for nursing facility care the person must be in medical need of that level of care. This decision is made by the Department of Health and Human Services or its designee.

Section 3.1 Individuals ineligible due to a transfer of assets

If the individual meets the medical need criteria but is ineligible for help with long term care costs due to a transfer of assets, the Categorically Needy Income Limit in Chart 4.1 is used to determine Medicaid eligibility.

Section 3.2 Individuals who are not in need of nursing facility level of care

- I. If an individual in a Nursing Facility does not meet the medical need criteria, that person may still be eligible for Medicaid coverage if the individual would be eligible if they were living in the community. Coverage is determined using the rules in Parts 6, 7 and 10 for an individual in the living arrangement, "living alone or with others". In this situation, Medicaid will not pay for nursing care costs nor can they be used toward meeting a deductible.
- II. Awaiting Placement for Residential Care (DAP or APRC). If an individual is in need of residential care but there are no beds available the individual may remain in the nursing facility as awaiting placement to a residential care facility. This coverage is for individuals converting from private pay including Medicare to Medicaid and found not in need of nursing facility level of care. MaineCare may help the individual with the cost of care if they meet eligibility criteria below.
 - A. The Office of Elder Services (OES) must establish that the individual meets non-financial criteria as identified in the MaineCare Benefits Manual.
 - B. The following financial criteria must be met:
 1. the asset and all non-financial criteria are the same as for an individual residing in a Residential Care Facility (RCF). See Part 13;
 2. countable income is determined using the same rules as for an individual residing in a RCF; and
 3. the individual's countable income must be less than the amount in Chart 3.8 A cost of care to be paid to the nursing facility is determined using the same rules as for an individual in a RCF. SSI and State Supplement benefits are counted when determining the cost of care.

If countable income is equal to or over the amount in Chart 3.8, the daily rate in Chart 3.8 can be used as the cost incurred for medical expenses in determining a "spend-down" (deductible).
 - C. If countable income is equal to or less than the Community Medicaid income limit for the individual's coverable group, they can get Medicaid coverage in addition to help with the cost of room and board under APRC.
 - D. If countable income is over this amount, but less than the amount in Chart 3.8, the individual is eligible for APRC only (not Medicaid).
 - E. Coverage under APRC ends when:
 1. the Office of Elder Services (OES) determines the individual no longer meets the non-financial criteria as identified in the MaineCare Benefits Manual; or
 2. the individual becomes financially ineligible.

SECTION 4 INSTITUTIONAL ASSET CRITERIA

Individuals must use their assets to meet their needs. Specific types and amounts may be retained by the individual and community spouse to meet current and future needs.

All available assets are to be used in determining eligibility. Countable assets are defined in Part 16. Asset limits are defined in Part 7, Section 1.

Unless exempt, a transfer of assets by the individual is subject to a penalty. Refer to Part 15 to assess if a transfer has occurred and if a penalty needs to be applied.

Countable assets of the individual must be under \$2000 on any day of the month for which eligibility is determined.

Section 4.1 Long Term Care Partnership Program

Maine has established a Long Term Care Partnership Program at the direction of the 122nd Legislature. This program provides incentives to Maine's citizens to purchase long term care insurance by disregarding some assets of the person, if they must apply for financial assistance for help with their long term care needs. This program shall take effect upon notice of approval of the corresponding State Plan Amendment by the Federal Centers for Medicare and Medicaid Services (CMS).

I. Insurance Policy

A. To meet the requirements of this MaineCare program, the long term care insurance policy must be a qualified State long term care insurance partnership as certified by the Maine Bureau of Insurance. Certification requires several factors which include:

1. the policy must cover an insured who was a Maine resident when coverage became effective under the policy. If the individual has a long term care partnership policy from another state which also participates in this program and has agreed to provide reciprocal disregards for Medicaid applicants with qualified partnership plans, Maine will provide the same disregards. The individual must still otherwise qualify for MaineCare assistance as detailed in part II. and III. of this section.
2. the policy must meet the definition of a qualified long term care insurance policy in the IRS Code §7702B(b) and 26 U.S.C. §7702B(b), and must meet the Model regulations specified in 42 USC §1396p(b)5
3. the policy must have been issued or re-issued on or after the effective date of the approved State Plan Amendment,
4. the policy must meet consumer protection standards of inflation protection, and its issuers are subject to training requirements of the Bureau of Insurance (Maine Bureau of Insurance Regulations 02-031 CMR chapter 425).

B. Prior to making application for MaineCare the individual must have used the available coverage and benefits under the approved Long Term Care Policy.

II. Eligibility for MaineCare

- B. All non-financial eligibility requirements as detailed in Section 1000 of this manual must be met.
- B. Applicant must meet the medical qualifications for assistance.
- C. Applicant's long term care insurance policy will be reviewed to determine if it meets the qualifications stated above, and to determine the extent of benefits paid so far by the terms of the policy.
- D. In addition to exempting assets routinely exempted under MaineCare rules, the amount of benefits paid to or on behalf of the insured applicant will be disregarded in the eligibility determination.

III. Post-Eligibility Considerations

- a. MaineCare benefits will only be paid for those expenses otherwise covered as outlined in the MaineCare Benefits Manual and for which the recipient's insurance policy has exhausted the benefits.
- b. The amount of the individual's assets disregarded under the above provisions continues to be disregarded post-eligibility throughout the lifetime of the individual, even if the disregarded assets have been transferred post-eligibility.
- C. If the policy benefits paid exceed the individual's assets at the time of application, additional assets up to the value of the benefits paid will be disregarded.

Section 4.2 Assets of Couples Residing in a Nursing Facility

If the total assets of a couple in the same room in a nursing facility exceed the standard for a couple, they can decide who will be the eligible spouse and assets can be transferred to the ineligible spouse. Each spouse is treated as an individual. Coverage can begin for the eligible spouse effective the month countable assets for the eligible spouse are below the standard for an individual.

If the couple reside in different rooms in the same facility or in different facilities, then each is treated as an individual when determining the asset limit. Coverage can begin for the eligible spouse effective the month countable assets for the eligible spouse are below the standard for an individual.

No spousal allowance of income or assets is determined since the ineligible spouse is not living in the community.

Section 4.3 Assets of the Institutionalized Individual with a community spouse

When an institutionalized individual has a community spouse, the couple's assets are looked at under special rules. These special rules determine how much of the couples assets are attributed to the community spouse and the institutionalized spouse. The amount attributed to the community spouse is called the Community Spouse Asset Allowance. The amount attributed to the institutionalized spouse is an available asset for the individual.

Determine the Community Spouse Asset Allowance -

- I. Total all countable assets owned by the community spouse and the institutionalized spouse (his, hers, theirs) on the first day of the month of application.
- II. The community spouse is allowed to keep all countable assets owned by the couple up to the amount in Chart 4.4. This is the Community Spouse Asset Allowance. Any share of the couple's assets over this amount is considered to be available to the institutionalized spouse.

The Community Spouse Asset Allowance may be increased over the amount of Chart 4.4 if the gross monthly income of the community spouse and the Community Spouse Monthly Income Allocation is less than the Monthly Income Allowance (See Section 6.1.1 in this Part for definitions). This determination is made through the Administrative hearings process described in Section 4.4 of this Part.

- III. The \$8000 savings exclusion (See Part 16, Section 2.46) is applied to the amount available to the institutionalized spouse. This exclusion is not applied to the total countable assets or to the Community Spouse Asset Allowance.
- IV. The result is compared to the asset limit for an individual.

The assets required to meet the Monthly Income Allowance shall be based on the Monthly Income Allowance set at the time of application.

Section 4.4 Hearing to Increase the Community Spouse Asset Allowance

Either the community spouse or institutionalized spouse may request a hearing if they have filed an application and they are dissatisfied with the determination of:

- I. The Community Spouse Asset Allowance.
- II. The amount of assets attributed to the institutionalized individual.

The hearing will be held within thirty days of the request.

The Department will make a determination of whether an amount greater than the Community Spouse Asset Allowance (Chart 4.4) is needed to raise the community spouse income to the Monthly Income Allowance.

If the individual agrees with the Department's decision, a hearing is requested using the Consent Decree in Appendix F.

If the individual disagrees with the Department's determination, s/he may request a face-to-face hearing.

A determination is made as follows on whether assets in addition to the Community Spouse Asset Allowance (Chart 4.4) are needed to meet the Monthly Income Allowance:

- I. Monthly Income Allowance and the Community Spouse Income Allocation are determined according to Section 6.1.1 of this Part.
- II. the community spouse's gross monthly income and the Community Spouse Monthly Income Allocation (from the institutionalized spouse) are subtracted from the Monthly Income Allowance. This is the income deficit.

- III. the Department will get two estimates of the price of a single premium lifetime annuity that will generate a payment equal to the deficit.
- IV. the average of these two estimates shall be substituted for the amount of assets attributed to or protected for the community spouse when the Community Spouse Asset Allowance (Chart 4.4) is less than the averaged cost of an annuity.

If the Community Spouse Asset Allowance in Chart 4.4 is greater than the averaged cost of the annuity, there shall be no substitution for the cost of an annuity.

- V. the spouse is not required to purchase this annuity.

Section 4.5 Transfer of Assets to the Community Spouse

Once the Community Spouse Asset Allowance has been established, the couple has twelve months to transfer the protected assets to the sole ownership of the Community Spouse.

Section 4.6 Non-Cooperation from the Community Spouse

If the community spouse does not make assets available to the institutionalized spouse, eligibility will not be denied if:

- I. the institutionalized spouse has assigned to the State any rights to support from the community spouse. A referral will be made to the Third Party Liability Unit (TPL) on behalf of the institutionalized spouse who gains eligibility for nursing care assistance when deemed assets are not made available by the community spouse;
- II. the institutionalized spouse is unable to execute an assignment of support due to physical or mental impairment. The State has the right to bring a support proceeding against a community spouse without an assignment under these conditions; or
- III. the State determines that denial of eligibility would cause an undue hardship. The consequences of being denied Medicaid for nursing care by itself does not constitute undue hardship.

SECTION 5 INCOME CRITERIA

Individuals must use their income to meet their needs.

Gross non-excluded income is used in determining eligibility. Gross non-excluded income is defined in Part 17 with the following exception: If the income of the institutionalized spouse is being reduced due to previous overpayments by government agencies, the reduced payment amount is used.

Income exclusions used for SSI - Related categories are used to determine gross non-excluded income.

Unless exempt, a transfer of income by the individual is subject to a penalty. Refer to Part 15 to assess if a transfer has occurred and if a penalty needs to be applied.

Section 5.1 Income Ownership

The income ownership rules for purposes of this Part supersede any State laws relating to community property or the division of marital property. The rules of ownership of income are as follows:

- I. Income payments made solely in the name of one spouse are available only to that respective spouse.
- II. When an income payment is made in the names of both spouses, one half is considered to be available to each, unless there is documentation to the contrary.
- III. If the payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income is available to each spouse in proportion to the spouse's interest. When both spouses' names are on the payment and no interest is specified, one half of the couples' interest is considered available to each spouse.
- IV. Income from a trust is counted to the extent it is considered available (Part 16, Section 2.52).

Section 5.2 Income Limits

Gross non-excluded income of the individual must be less than the private rate for a semi-private room in the facility where the individual resides.

Section 5.2.1 Income below the Categorically Needy Income Limit

If an individual has income below the categorically needy income limit (see Chart 4.1). See Section 6 of this Part to determine the cost of care.

Section 5.2.2 Income equal to or over the Categorically Needy Income Limit

If an individual has income equal to or over the categorically needy income limit, but under the private rate for the facility a deductible must be met.

Depending on the gross income the deductible is always met by incurring the Medicaid rate or private rate for the facility. Specifics on which rate to use are explained below. Eligibility occurs on the first day of the month of eligibility for the six month period.

The deductible is met as follows:

- A. Combine all gross unearned income.
- B. Subtract the \$20.00 Federal Disregard, where applicable. The remainder is the net unearned income.
- C. Combine all gross earned income.
- D. Subtract any remainder of the \$20.00 Federal Disregard not deducted for the unearned income.
- E. Subtract the earned income disregard of \$65.00.
- F. Divide the remaining earned income by two. The remainder is the net earned income.
- G. Combine the net earned and unearned income.
- H. Subtract the Protected Income Level (PIL) for one (See Chart 5).
- I. Multiply this figure by six to determine the total for the deductible period. This is the individual's deductible.
- J. Subtract the cost of:

1. Medicare payments of the individual.
2. Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in an AFH, FRBH, CRBH, RCF, or AFCH, (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (See Part 13).

Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

Note: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective, TPL will arrange for premium payment.

3. Outstanding medical bills incurred by the individual for necessary medical services (See Part 10).
- K. The balance is the remaining deductible. The deductible is met as follows:
1. If the gross income is in excess of the Categorical Income limit (Chart 4.1) and less than the Medicaid rate, subtract the Medicaid Rate for the six month period.
 2. If the gross income is equal to or over the Medicaid rate for the facility but less than the private rate, subtract the private rate for the six month period.

SECTION 6 COST OF CARE

Institutionalized individuals are responsible for paying toward their cost of care for stays of a full calendar month. This includes those who may have paid privately for a portion of the month.

If an individual moves from one nursing facility to another the payment goes to the facility where the individual was residing on the first day of the month. If the individual moves from one facility to another on the first day of the month, the facility to which the individual moves is paid the cost of care.

If the individual was institutionalized on the first day of the month for which eligibility is being requested, the cost of care begins with that month.

If an individual was living in the community on the first day of the month for which eligibility is being requested then the first cost of care is owed for the following month.

If the individual was in acute status in a hospital for a full calendar month the individual may not owe anything for hospital costs due to payments from Medicare and/or other insurance. A cost of care is still determined. The hospital will be responsible to collect any portion that is actually owed.

When, after third party payments, the balance owed is less than the individual's cost of care, the lesser amount will be collected by the facility. This also applies when an individual is in a skilled nursing facility and covered by Medicare and QMB. A cost of care will be established. Since QMB covers the Medicare co-insurances and deductibles no cost of care will be collected until the Medicare days end.

There is no cost of care for SSI recipients in a medical institution if the Social Security Administration determines that the individual will be returning home within three months of entering the facility.

Individuals who receive SSI and whose total income is less than \$60.00 (based on being in a nursing facility) have no cost of care.

The amount of an individual's cost of care may be adjusted without advance notice (See Section 6.2 of this Part).

Individuals who are no longer in a nursing facility are to be refunded their cost of care for that month by the facility. If the individual is entering a AFH, FRBH, CRBH, RCF, or AFCH (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (see Part 13). a cost of care may be owed to the new provider based on the eligibility requirements for this new program.

Section 6.1 Determining the Individual's Cost of Care

The individual's cost of care is what the individual is expected to pay towards the cost of their care at the institution. The cost of care is determined by considering the individual's income minus certain expenses and the Community Spouse Monthly Income Allocation.

For individuals who are categorically eligible, there is one determination process to follow. For those who are medically needy the determination process varies, depending on the individual's income.

For any month that an individual is considered to be institutionalized, a community spouse's income is never used in determining the cost of care, including a partial month, except in determining the Community Spouse Monthly Income Allocation.

Section 6.1.1 Determining the Community Spouse Monthly Income Allocation

At the time of application a determination is made of the Community Spouse Monthly Income Allocation.

The Community Spouse Monthly Income Allocation is the amount of income the institutionalized spouse is allowed to give to the community spouse before paying the cost of care.

Definitions:

Minimum Monthly Income Standard – This is an amount set by Federal law used in the formula to determine the Monthly Income Allowance (See Chart 4.4).

Monthly Income Allowance – This is the Minimum Income Standard plus excess shelter costs.

Monthly Excess Shelter Standard – This is an amount set by Federal law. If the community spouse has shelter costs that exceed this amount, the excess can

be used in determining the Community Spouse Monthly Income Allowance (See Chart 4.4).

Maximum Monthly Income Allocation – This is an amount set by Federal law that establishes the limit on income that can be allocated to the community spouse.

Community Spouse Monthly Income Allocation – This is the Monthly Income Allowance minus the community spouse's income.

The Community Spouse Monthly Income Allocation is determined as follows:

I. Determine if the community spouse has excess shelter costs:

Total the following shelter expenses for the community spouse's primary residence:

- A. rent or mortgage payment (principal and interest);
- B. taxes, homeowner's and renter's insurance payments;
- C. maintenance charges for condominiums or cooperatives; and
- D. the Standard Utility Allowance used by the State in the Food Supplement Program. The utility standard will be reduced to the extent it is included in cooperative or condominium maintenance fees (See Appendix J for the computation of the utility standard).
 1. If the countable monthly shelter expenses are less than or equal to the Monthly Excess Shelter Standard (Chart 4.4) no shelter costs are given in the allowance.
 2. If the countable monthly shelter expenses are greater than the Monthly Excess Shelter Standard, the difference is the Excess Shelter Cost.

II. Combine the excess shelter cost with the Minimum Monthly Income Standard. This figure may not exceed the Maximum Monthly Income Allocation. This is the Monthly Income Allowance.

III. Determine the gross monthly income of the community spouse including TANF/SSI payments. Include income actually generated from the Community Spouse Asset Allocation.

IV. Subtract gross monthly income from the Monthly Income Allowance amount in II. above. (If the gross monthly income of the community spouse is equal to or greater than the Monthly Income Allowance, no income allocation is made from the institutionalized spouse).

V. The balance is the Community Spouse Monthly Income Allocation. This income is allocated from the institutionalized spouse to the community spouse.

The Monthly Income Allowance must not exceed the Maximum Monthly Income Allocation (See Chart 4.4).

This allocation can only be increased by:

- I. a court order specifying a higher amount, or

- II. an administrative hearing that establishes that the community spouse needs income above the Minimum Monthly Income Allowance due to exceptional financial circumstances.

Examples:

1. Excess Shelter	\$ 547
Minimum Monthly Income Standard	+ \$1839
Monthly Income Allowance	\$2386
Community Spouse Gross Income	- \$ 500
Community Spouse Monthly Income Allocation	\$1886

2. Excess shelter	\$1098
Minimum Income Standard	+ \$1839
Monthly Income Allowance	\$2937

The Monthly Income Allowance exceeds the cap set by the Maximum Monthly Income Allocation. This limits the Allowance to the Maximum Monthly Income Allocation.

Maximum Monthly Income Allocation (Chart 4.4)	\$2841
Minus Community Spouse gross income	- \$ 700
Community Spouse Monthly Income Allocation	\$2141

Section 6.1.2 Administrative Hearing Process for Income

The community spouse or institutionalized spouse may request an administrative hearing if they have filed an application and they are dissatisfied with the determination of:

- I. the Monthly Income Allowance;
- II. the Community Spouse Monthly Income Allocation; and/or
- III. the excess shelter cost.

Either spouse may request a revision of the Monthly Income Allowance if they can establish a need, due to exceptional circumstances, which would create a financial hardship if more funds were not made available. This may occur either through the hearing process or a court order. The circumstances that caused the request are subject to departmental review yearly to determine if continued receipt of the increased allowance is warranted.

If either spouse establishes that the community spouse needs income above the level otherwise provided by the Monthly Income Allowance, due to exceptional circumstances resulting in significant financial duress, there shall be supplemented to the Monthly Income Allowance, an amount adequate to provide such additional income as is necessary. "Financial duress" is defined as the inability of the community spouse to meet current monthly household and/or medical expenses. "Such additional income as is necessary" is defined as the amount by which the community spouse's actual and necessary household and/or medical expenses exceed the Monthly Income Allowance.

In order to establish exceptional circumstances resulting in significant financial duress, either spouse must establish that the community spouse has made use of resources and income to meet current monthly household and medical expenses, and that he or she has no other ability to meet those expenses. Exceptional circumstances will not be deemed to exist where application of the Monthly Income Allowance results in a change or inconvenience to the lifestyle of the community spouse if necessary monthly household and medical expenses can nevertheless be met.

Once an application has been filed, either spouse may request an administrative hearing to increase the Community Spouse Asset Allowance (see Section 4.2 of this Part) if the community spouse's monthly income does not meet the Monthly Income Allowance. The additional assets are requested so that they will generate income and raise the community spouse's total available income to meet the Monthly Income Allowance. The additional allocation of assets to the community spouse may be revised as of the month of application. The Community Spouse Asset Allowance may not be revised prior to that month.

Section 6.1.3 Dependent Allocation

When an institutionalized individual has dependents living at home, an allocation may be allowed for their needs. The method of determining the allocation amount depends on whether there is a community spouse.

For purposes of this section, a dependent is defined as a minor or dependent child, dependent parent(s), or dependent sibling(s) of the institutionalized individual or community spouse, who are residing with the community spouse. These dependents are individuals who may be claimed by the institutionalized or community spouse for tax purposes under Internal Revenue Code.

I. Dependent Allocation with a Community Spouse -

To determine the allocation:

- A. Determine the gross monthly income of each dependent member including SSI, TANF, and adoption assistance payments. Assets are considered only to the extent of interest or dividend income being generated.
- B. Compare the gross income of each individual to the Minimum Monthly Income Standard. (See Chart 4.4)

If the gross monthly income is equal to or greater than the Standard, no allocation is made.

If the gross monthly income is less than the Minimum Monthly Income Standard, subtract the income from the Standard. Divide the remainder by three. The resulting figure is the allocation for each dependent.

II. Dependent Allocation Without a Community Spouse –

To determine the allocation:

- A. determine the gross monthly income of all dependents living together including SSI, TANF and Adoption Assistance payments. Assets are considered only to the extent of income being generated by the assets.

- B. compare the gross income of all dependents living together to the Full Need Standard in Chart 2 for the appropriate unit size. For example, three dependents would use the unit size of three.

If gross monthly income is equal to or greater than the standard, no allocation is made.

If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.

Section 6.1.4 Calculating Cost of Care for Individuals below the Categorical Income Limit

- I. Determine the individual's gross monthly income.
 - A. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual's death (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if the election is irreversible and the reduction amount does not exceed \$1,000 per month.
 - B. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction is \$1000/child/month.
- II. An adjustment may be made if there are current federal, state or local income tax deductions from the individual's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

Examples:

- 1. Last year \$600 was the tax liability. \$80.00 per month is withheld for income tax. Only \$50.00 per month can be allowed as a deduction as this is the current tax liability ($\$600 \div 12 = \50.00).
- 2. Last year \$600 was the tax liability. \$25.00 per month is being withheld for income tax. A deduction of \$50.00 per month is allowed as a deduction as this is the current tax liability ($\$600 \div 12 = \50.00).

Note: If an institutionalized individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

- III. Subtract the appropriate personal needs allowance. This is:
 - A. \$40.00 per month, or
 - B. \$130.00 for the following individuals:
 - 1. those receiving the reduced VA pension of \$90.00 who are not in a VA facility, or
 - 2. those in VA nursing facilities who receive a VA pension and are single with no dependents or are the surviving spouse with no dependents

- C. up to the maximum dependent allowance (Chart 4.2) for an individual who participates in a sheltered workshop. To determine the actual amount:
1. Subtract \$40.00 from any unearned income.
 2. Subtract any remainder of the \$40.00 from earned income.
 3. Subtract \$50.00 from any remaining earnings.
 4. Subtract one-half of any remaining earnings.

The deductions of \$40.00 and \$50.00 and the one-half remainder figure are added together. This figure is the personal needs allowance. This figure may not exceed the maximum dependent allowance (Chart 4.2).

IV. Subtract the cost of:

- A. Medicare payments for the individual.
- B. Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a RCF, CRBH, Nursing Facility, or covered by a Home and Community Based Waiver.

Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

Note: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability (TPL) should be contacted to assess cost effectiveness. If cost effective, TPL will arrange for premium payment.

- C. Certain Medical expenses:
1. Paid or unpaid medical expenses incurred by a Medicaid covered individual, while residing in the facility, for necessary medical services as long as:
 - a. the service is not covered in the per diem rate of the facility as determined by the MaineCare Benefits Manual.
 - b. the service is not one the facility is expected to provide. The facility is expected to provide services contained in a written order or plan of care established by the individual's physician.
 2. A medical expense will not be deducted from the cost of care if:
 - a. the expense was covered by insurance (including Medicare).
 - b. the expense was not covered due to a Medicaid penalty period of ineligibility.
 - c. the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Office of Elder Services (OES).

- d. the expense is the unpaid cost of care to a medical institution or a waiver agency during periods of Medicaid coverage.
- e. the expense was for a Medicaid covered service and the individual was covered by Medicaid.

V. Subtract any spouse's and/or dependent's allocation. These figures are determined in Section 6.1.1 or 6.1.3 of this Part.

VI. The remainder is the individual's cost of care.

Note: If there is a partial month transfer of asset penalty the individual may be responsible for an amount in addition to their cost of care (See Part 15, Section 1.8).

Example:

John enters the hospital on 2/17 from home. He moves to a nursing facility on 2/27. He is married and his wife Joan continues to live in their apartment. They have a \$13,500 certificate of deposit from which they receive the interest monthly. They also have a checking account with a balance of \$738.29. John receives Social Security benefits of \$729.50 and Joan receives \$529.80. The subsidized rent is \$550.00 monthly, including heat and lights.

Income Allocation

<u>Joan's income</u>		<u>John's income</u>	
\$529.80	Social Security	\$729.50	Social Security
+ 65.26	interest income		
<u>\$595.06</u>			
\$550.00	Rent		
+ 24.00	Telephone		
<u>\$574.00</u>			
-552.00	(30% of \$1839 – Chart 4.4))		
<u>\$ 22.00</u>	Excess shelter		
+1839.00	Minimum Monthly Income Standard (Chart 4.4)		
<u>\$1861.00</u>	(\$2841 maximum – Chart 4.4)		
- 595.06	Joan's income		
<u>\$1265.94</u>	Income allocation to community spouse		

Cost of Care

\$729.50	John's income
- 40.00	personal needs
<u>\$689.50</u>	
- 99.90	Medicare premium (Appendix C)
<u>\$589.60</u>	
-1265.94	Income allocation to community spouse
<u>0.00</u>	Cost of care

Section 6.1.5 Calculating the Cost of Care for Individuals with Income Equal to or Over the Categorical Income Limit and less than the Private Rate

An individual is not expected to pay more than the Medicaid rate of the facility for a cost of care.

Part 14 Individuals in Medical Institution

If the individual's gross income is over the Categorical Income limit but under the Private rate of the facility, multiply the daily Medicaid rate of the facility by thirty-one days. Compare the cost of care as calculated in Section 6.1.4 of this Part to the thirty-one day Medicaid rate. The individual is responsible to pay the lesser of the two amounts, either the cost of care or the Medicaid rate.

Example:

Dick Reel entered a nursing facility on 1/17/08, from home. Dick receives \$2972 in Civil Services benefits, \$798 in Social Security benefits and a pension of \$1800 monthly. The private rate is \$200 per day and the Medicaid rate is \$100 per day.

Income	
\$ 2972.00	Civil Service
\$ 798.00	Social Security
\$ 1800.00	Pension
\$ 5570.00	Total
Deductible (See Section 5.2 of this Part)	
\$ 5570.00	Dick's gross income
- 20.00	Federal disregard
\$ 5550.00	
- 315.00	PIL (1)
\$ 5235.00	
X 6	Deductible period
\$ 31410.00	Deductible
- 578.40	Medicare premiums
\$ 30831.60	
- 18600.00	Medicaid rate for 6 months
\$ 12231.60	

Because there is a remaining deductible use the Private rate instead of the Medicaid rate for 6 months.

\$ 30,831.60	
- \$ 37,200.00	Private rate for 6 months
0.00	Remaining deductible

Cost of Care	
\$ 5570.00	Dick's gross income
- 40.00	Personal needs
\$ 5530.00	
- 96.40	Medicare premium
\$ 5433.60	Cost of Care

Dick's cost of care will be \$3100 monthly. This is the Medicaid rate for the facility and it is less than the cost of care calculated using the rules in section 6.1.4.

Section 6.2 Changes in the Cost of Care

- I. The individual paid a cost of care that was more than what was actually due. When this was due to Department error, the individual cost of care is

adjusted retroactively up to one year from the date the error is discovered by the Department. When this was due to error by the individual, no adjustment is made.

- II. The individual paid a cost of care that was less than what was actually due. Whether this is due to error by the Department or the individual, the individual's cost of care is adjusted retroactively up to three months from the date the error is discovered by the Department without advance notice. This includes an adjustment for a lump sum payment (see Section 6.4 of this Part).

Section 6.3 Non-Covered Medical Expenses

Verified medical expenses that can be deducted from the cost of care are deducted for the month following the month the bills are received in the office.

For individuals who die and had incurred non-covered medical expenses, the last cost of care can be adjusted for the month in which they die.

Individuals who only receive \$40.00 per month SSI and have a \$0 cost of care are not reimbursed for non-covered medical expenses.

Example:

Jack Snow purchases two bottles of Tylenol at \$11.49 each and two hearing aide batteries at \$10.00 each. Receipts are submitted on 3/5. Gross Social Security is \$891.80.

Cost of Care

\$891.50	Gross Social Security
- 40.00	Personal needs
- 96.40	Medicare premium
- <u>20.00</u>	Uncovered medical expenses (see note below)
\$735.10	Cost of care

Note: Cannot allow Tylenol - (generic brand for Tylenol is supplied by the facility. If Tylenol is prescribed by a physician and included in the plan of care, it is supplied by the facility and the cost is not allowed as an uncovered medical expense).

Section 6.4 Lump Sums

All lump sum payments, with the exception of SSI, are treated as income in the month received.

Any portion of a lump sum remaining the following month is an asset. Social Security and SSI retroactive payments are an excluded asset for nine months.

Section 6.5 Medicare Buy-In for Institutionalized Individuals

Medicare Buy-In is determined the same as for those who live in the community. See Part 8 for a description of the Buy-In programs.

If a couple is residing in the same room they are considered to be living together. If they are residing in separate rooms they are considered to be living apart.

Aid and Attendance is not used in this process.